

JAMES E. RISCH - Governor KARL B. KURTZ - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

September 8, 2006

Earl Fitzpatrick Gooding County Memorial Hospital P.O. Box 418 Gooding, ID 83330

Re: Provider #131302

Dear Mr. Fitzpatrick:

FILE COPY

This is to advise you of the findings of the Medicare Recertification and Swing Bed survey of Gooding County Memorial Hospital which was concluded on August 29, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form HCFA-2567, listing Medicare Deficiencies and a similar State Form listing no state deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

- 1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for <u>all</u> individuals potentially impacted by the deficient practice.
- 2. Identify the person or discipline responsible for monitoring the deficient system to insure compliance is achieved and maintained. Included how the monitoring will be done and at what frequency.
- 3. Identify the date each deficiency has been, or will be, corrected.
- 4. Sign and date the form(s) in the space provided at the bottom of the first page.

Earl Fitzpatrick September 8, 2006 Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by September 21, 2006, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office.

Sincerely,

PENNY SALOW

Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Supervisor

Non-Long Term Care

PS/mlw

Enclosures

CENTERS FOR MEDICARE & MEDICATO SERVICES  TATAMENTO FOR PROPICIONES  INTERESTANDA FOR SUPPLIER  SUMMARY STREET ADDRESS, CITY, STATE, JP CODE  1120 MONTANA STREET  GOODING COUNTY MEMORIAL HOSPITAL  SUMMARY STATEMENT OF DEPICIENCY MUST BE PROCEEDED BY FULL  PREFIX  FROULTORY OR AS DEMINY WAS TREMENT OF DEPICIENCES BY FULL  REGULATORY OR AS DEMINY MAY STREET  GOODING, ID 33330  INITIAL COMMENTS  The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyor conducting the Medicare recertification survey was:  Penny Salow, R.N., H.F.S.  C 381  485.845(d)(1) RESIDENTS RIGHTS (483.10(b) (3))  The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including the fight to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and policies, it was determined that the Critical Access Hospital (TAH) failed to ensure 4 of 4 Swing-bed status on 4/25/06 and discharged on 5/2/06. The closed record did not contain a signed list of patients' rights to other evidence the patient had been notified of her rights or other reviewed and the following issues were identified:  1. Closed records were reviewed and the following issues were identified:  2. Comment #1 was admitted to Swing-bed status on 4/25/06 and discharged on 5/2/06. The closed record did not contain a signed list of patients' rights to other evidence the patients had been notified of her rights. The findings include:  2. Comment #1 was admitted to Swing-bed status on 4/25/06 and discharged on 5/2/06. The closed record did not contain a signed list of patients' rights to other evidence the patients had been notified of her rights.	DEPART	MENT OF HEALTH	AND HUMAN SERVICES	and the second control	MACHAIL IS I	u spanie programa in mengapi magaman magaman naga kabupatanan mana mata mengan mengan menganakan di Amerika Se		-09/04/2006- APPROVED
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Any deficiency statement ending with an asterisk (\*) derivers a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  131302    ASILIDING   DRIVER   COMPLETED	DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES	a distribution of the con-			FORM	: 09/04/2006 I APPROVED
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found in closed records for Patients #1, 2, 3 or 4.	C 361	* Patient #2 was ad 3/19/06 and dischar record did not contarights or other evide notified of his rights  * Patient #3 was ad 4/29/06 and dischar record did not contarights or other evide notified of her rights  * Patient #4 was add 4/24/06 and dischar record did not contarights or other evide notified of her rights  * Patient #4 was add 4/24/06 and dischar record did not contarights or other evide notified of her rights  2. The Director of Hanagement was in PM. She confirmed documentation of patients were last recontained a 3-page (PATIENT) RIGHTS page of the rights do the patient or their redocument, a place to was unable to sign, witness to sign, and document. The patients	mitted to Swing-bed status on reged on 3/23/06. The closed ain a signed list of patients' ence the patient had been or ged on 5/5/06. The closed ain a signed list of patients' ence the patient had been din a signed list of patients' ence the patient had been din a signed list of patients' ence the patient had been din a signed list of patients' ence the patient had been din a signed list of patients' ence the patient had been din a signed list of patients' ence the patient had been din a signed list of patients' ence the patient had been districted the patient had been districted encoded at light and light an	C	361	Sharon Bohman, Social W responsible for monitor Bed Rights and Responsi signatures with Lorrain	ing Swin bilities e	g

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/04/2006 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		131302	B. WIN	IG	7/45/4/11/11/11/11/11/11/11/11/11/11/11/11/1	08/2	9/2006
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	3/2000
GOODIN	G COUNTY MEMORIA	AL HOSPITAL		11	120 MONTANA STREET OODING, ID 83330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
C 385	A facility must care and in an environm maintenance or eni quality of life. The fongoing program of accordance with the interests and the psychosocial well-be. The activities prograulified professional who-ols licensed or registate in which praction is eligible for certification specialis professional by a reor after October 1, old Has 2 years of expectational program which was full-time in a health care set ols a qualified occupational therap	nancement of each resident's facility must provide for an activities designed to meet, in ecomprehensive assessment, ephysical, mental, and eing of each resident.  am must be directed by a all who is a qualified on specialist or an activities distered, if applicable, by the ticing; and fication as a therapeutic to ras an activities ecognized accrediting body on 1990; or perience in a social or most within the last 5 years, 1 of in a patient activities program ting; or upational therapist or	C3		The Activity Policy has reviewed/revised and ap 9/19/06. (SB #101) Nursare responsible for assethe patient's activity and then creating an acplan. Nursing staff will under the direction of contracted Occupational Connie Van Kleek.  An activity assessment activity form have been Nursing staff were inforthe changes 9/20 and 21, will implement on the nebed admission. (see attended will be designated that the Occupational That ocreate appropriate gractivities.  The QA indicator is: An activity plan will be oped for each swing bed with an activity log main the threshold is set at	proved or sing stafessing interests tivity and created. Therapis form and created. The side of work achments of work nerapist roup advect entained.	t,
	Based on record re determined the CAI Swing-bed patients assessed for activit potential that Swing provided with mean include:	s not met as evidenced by: view and staff interview, it was I failed to ensure 4 of 4 (#1, 2, 3 and 4) were ies interests. This created the ipbed patients would not be ingful activities. The findings			The Social Worker will rethe charts to ensure an plan has been created and aily activity is being 100% of the swing bed pacharts will be reviewed next 12 months for complementoring. After 12 monthe frequency of monitor	activity d the used. tient over the iance nths,	

		AND HUMAN SERVICES & MEDICAID SERVICES			inanimana andaha kana maramat timan nan bada ke dendari saha nga 1900 andah sibandah na distribu. 🥫 sahida	FORM	: 09/04/2006 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		131302	B. WI	√G		08/2	9/2006
	ROVIDER OR SUPPLIER  G COUNTY MEMORIA	AL HOSPITAL		1	REET ADDRESS, CITY, STATE, ZIP CODE 120 MONTANA STREET GOODING, ID 83330	00/2	3/2000
(X4) ID PREFIX TAG				ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
C 385	* Patient #1, a 92 yeto Swing-bed status on 5/2/06. The patidocument titled "Dis Assessment", which 4/19/06 by the sociation titled "Swing Brelated to "Activity Prompleted.  * Patient #2, an 88 y Swing-bed status or 3/23/06. The patient document titled "Dis Assessment", which 3/10/06 by the sociation titled "Swing Brelated to "Activity Prompleted.  * Patient #3, a 57 yeto Swing-bed status on 5/5/06. The patient patient #3, a 57 yeto Swing-bed status on 5/5/06. The patient #3, a 57 yeto Swing-bed status on 5/5/06. The patient #3	cowing issues were identified: ear old female, was admitted on 4/25/06 and discharged ent's record contained a scharge Planning had been completed on all worker. The section of the ed Assessment", which tursuit Patterns", had not been wear old male, was admitted to a 3/19/06 and discharged on all worker. The section of the ed Assessment", which tursuit Patterns", had not been all worker. The section of the ed Assessment", which tursuit Patterns", had not been war old female, was admitted on 4/29/06 and discharged ent's record did not contain a led Assessment" relating to	C	385		ecision	
	* Patient #4, an 82 y to Swing-bed status on 4/30/06. The par completed assessm	rear old female, was admitted on 4/24/06 and discharged tient's record did not contain a ent for activity interests.					
	for completing the a interviewed on 8/29/ she was not aware of	worker, who was responsible ctivity assessments, was 06 at 11:25 AM. She stated of the requirements for hts for Swing-bed patients.		ALABAMAMAMAMAMAMAMAMAMAMAMAMAMAMAMAMAMAM			manus de la companya

		AND HUMAN SERVICES  & MEDICAID SERVICES	And a big and a	,		FORM	09/04/2006 APPROVED
STATEMENT OF DEFICIEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N		IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		131302	B. Wil	√G		08/2	9/2006
NAME OF PROVIDER OR GOODING COUNTY		AL HOSPITAL		1	REET ADDRESS, CITY, STATE, ZIP CODE 120 MONTANA STREET GOODING, ID 83330	08/2	9/2006
PRÉFIX (EACH D	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
The facility services to practicable well-being A facility of qualified services in limited to service in limited to service a health of individuals.  This STAN Based on and policide ensure 4 of were proved the proved the proved the proved in the proved service in	y must proper attain or e physica of each of e	than 120 beds must employ a ker on a full-time basis.  orker is an individual with a social work or a bachelor's services field including but not special education, eling, and psychology; and sed social work experience in g working directly with  s not met as evidenced by: view and review of records determined the CAH failed to g-bed patients (#1, 2, 3 and 4) psychosocial assessments. tential for unmet psychosocial	C		The Social Worker has conother agencies and creat psychosocial assessment be used on all swing bed The Psychosocial assessment (SB 102) has been updated reflect the role of the Worker in doing the psych assessment and in the abstite Social Worker the informal RN beginning the assessment Formal Worker and number will be fulfilling these redefined roles effective (see attachment SB 102 at Psychosocial assessment).  The QA indicator is: Admissions will reflect associal assessment being oper policy 100% of the time of the swing bed charted the threshold set at After 12 months, the free monitoring will be re-evaluated upon the threshold met, monitoring may decremal remains at 100% chart Quality Monitoring will be the inpatient nursing under the direction of Lorent Reinhardt, CNO.	ed a new tool to patient ent poli d to Social hosocial sence of patient ent. rsing starts will a psychocomplete ime. arts will 12 month 13 month 14 month 15 month 16 month 16 month 17 month 18	s. cy aff 6.

CENIE	RS FOR MEDICARE	& MEDICAID SERVICES					. 0938-0391
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTI DIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	131302			G_		00/00/000	
	ROVIDER OR SUPPLIER	AL HOSPITAL		1	REET ADDRESS, CITY, STATE, ZIP CODE 120 MONTANA STREET GOODING, ID 83330	1 08/2	9/2006
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
C 386	Swing-bed status of 3/23/06. No documal psychosocial asset * Patient #3, a 57 yet to Swing-bed status on 5/5/06. No docum indicate a psychosocial completed.  * Patient #4, an 82 yet to Swing-bed status on 4/30/06. The paragraph psychosocial asset 2. Swing-bed policies manual contained a "Psychosocial/Dischar form titled "PATIE ASSESSMENT". Toontained areas related and dischare vidence was found utilized to assess Patients. She stated she was not psychosocial asset patients. She stated	n 3/19/06 and discharged on tentation was found to indicate essment had been completed.  Bear old female, was admitted an admitted es on 4/29/06 and discharged ementation was found to ocial assessment had been expear old female, was admitted an admitted es on 4/24/06 and discharged estient's record did not contain a sment.  Bes were reviewed. The policy titled expenses ment', as well as expenses ment', as well as expenses ment form attended to sleep, sight and eation, religion, activity pursuits arge planning needs. No it to indicate the form had been expenses at 1, 2, 3 or 4.  I worker, who was responsible expenses for swing-bed dishe used the form the rused. She was not aware of	C 3	86			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			AND HUMAN SERVICES	Annual Company of the	,	delakunin de un fan in Prop lef ar Carbellorf diel in 1995 fe de ar Fari a fan de helde dêr fêde	FORM	: 09/04/2006 APPROVED
NAME OF PROVIDER OR SUPPLIER  GOODING COUNTY MEMORIAL HOSPITAL  STREET ADDRESS, CITY, STATE, ZIP CODE 1120 MONTANA STREET GOODING, ID 83330  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  COMPTON TO THE APPROPRIATE DEFICIENCY)  ONE ADDRESS, CITY, STATE, ZIP CODE 1120 MONTANA STREET GOODING, ID 83330  (CA) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		i	1			URVEY
GOODING COUNTY MEMORIAL HOSPITAL  STREET ADDRESS, CITY, STATE, ZIP CODE  1120 MONTANA STREET  GOODING, ID 83330  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY)  STREET ADDRESS, CITY, STATE, ZIP CODE  1120 MONTANA STREET  GOODING, ID 83330  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			131302	B. WII	NG		00/2	0/2006
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Or 2005 ARE 0.454 N. Market Statement of Deficiencies id Prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Or 2005 ARE 0.454 N. Market Statement of Deficiencies id Prefix (EACH CORRECTION (COMPANY) (EACH CORRECTION SHOULD BE DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·				1	120 MONTANA STREET	<u>  08/2</u>	9/2006
C 395 485.645(d)(6) COMPREHENSIVE CARE PLANS C 395 Comprehensive Care Plans	PRÉFIX	X (EACH DEFICIENCY MUST BE PRECEEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	II D BE	(X5) COMPLETION DATE
The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This STANDARD is not met as evidenced by:  Based on staff interview and review of records	C 395	(483.20(k)(1))  The facility must de plan for each reside objectives and time medical, nursing, nursing, nursing, nursing, nursing, nursing, nursing, nursin	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This STANDARD is not met as evidenced by:			The care plan policy has reviewed/updated and app on 9/19/06. (SB 107). Tadmitting RN will begin comprehensive care plan admission which means shwill develop a new care (not the acute care plan comprehensive care plan completed within the timframes as stated in the This change was discusse nursing staff meetings of and 9/21, 2006.  The QA indicator is: "An individualized care will be initiated on admito swing beds."	been proved the the on plan ). The will be policy. d at n 9/20 plan ission	
and policies, it was determined the CAH failed to ensure care plans were fully developed for 4 of 4 Swing-bed patients (#1, 2, 3 and 4), whose closed records were reviewed. This created the potential for unmet needs. The findings include:  1. Swing-bed patient records were reviewed on 8/28/06 and the following issues were identified:  * Patient #1, a 92 year old female, was admitted to Swing-bed status on 4/25/06 and discharged on 5/2/06. No documentation was found to indicate a comprehensive care plan had been developed.  * Patient #2, an 88 year old male, was admitted to Swing-bed status on 3/19/06 and discharged on 5/2/06 and discharged on 3/19/06 and discharged on 5/2/06 and discharg		and policies, it was ensure care plans we swing-bed patients closed records were potential for unmet at 1. Swing-bed patient 8/28/06 and the folkown and the folkown are swing-bed status on 5/2/06. No docu indicate a comprehend developed.	determined the CAH failed to vere fully developed for 4 of 4 (#1, 2, 3 and 4), whose e reviewed. This created the needs. The findings include: Intrecords were reviewed on owing issues were identified: ear old female, was admitted on 4/25/06 and discharged mentation was found to ensive care plan had been rear old male, was admitted to			charts will be reviewed the next 12 months for compliance monitoring. 12 months, the frequency monitoring will be re-ev and a decision made as tor less monitoring.  The Social Worker will r the charts for initial c creation with Lorraine Reinhardt CNO providing	over After of aluated o 100%	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE COMPL	SURVEY
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	ROVIDER OR SUPPLIER  G COUNTY MEMORIA	AL HOSPITAL		1	REET ADDRESS, CITY, STATE, ZIP CODE 120 MONTANA STREET GOODING, ID 83330	1 08/	29/2006
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X5) COMPLETION DATE
	* Patient #3, a 57 ye to Swing-bed status on 5/5/06. No docu indicate a care plan  * Patient #4, an 82 y to Swing-bed status on 4/30/06. The pacare plan.  2. Swing-bed policie manual contained a SWING BED FROM listed the medical recharts. The last iter CARE PLANS". No indicate nursing care for Patients #1, 2, 3  3. The Director of Hanagement was in PM. She confirmed records lacked nursi explained that patier Swing-bed records were then stacute care records for The records contains However, no system	dentation was found to indicate an developed.  Bear old female, was admitted a con 4/29/06 and discharged amentation was found to had been developed.  Wear old female, was admitted a con 4/24/06 and discharged attent's record did not contain a co	C 3	95			
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